U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 19 June 2006

In the Matter of

CARL E. MANN
Claimant

Case No.: 2003 BLA 6515

v.

PITTSBURG & MIDWAY COAL MINING CO.
(SUCCESSOR TO KAISER COAL CORPORATION)
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Leonard J. Stayton, Attorney
For the Claimant

Mr. Keith Utley, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

This matter involves a claim filed by Mr. Carl Mann for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

Initial Claim
(DX 1)[1]

Initial Adjudication

Mr. Mann filed his first application for black lung disability benefits on May 8, 1984. After a pulmonary examination, the U.S. Department of Labor ("DOL") denied the claim on July 5, 1984 because Mr. Mann failed to prove total disability. On August 31, 1984, Mr. Mann appealed and the case was forwarded to the Office of Administrative Law Judges ("OALJ") on November 21, 1984. However, due to bankruptcy proceedings involving the responsible operator and a court-ordered automatic stay, the case was remanded to DOL on May 19, 1987. Upon reconsideration of the medical evidence, DOL again denied the claim on April 10, 1991 due to the absence of total disability and forwarded the clam to OALJ on January 2, 1992. Once again, however, on March 20, 1992, the case was returned to DOL in order to designate the bankruptcy successor to the responsible operator. On June 8, 1992, DOL again sent the case to OALJ.

Administrative Law Judge Decision

Administrative Law Judge Quentin P. McColgin conducted a hearing on January 13, 1993. On September 21, 1993, Judge McColgin denied the claim. Although the evidence established the presence of coal workers' pneumoconiosis, Judge McColgin concluded the preponderance of the medical evidence failed to establish the presence of a totally disabling pulmonary impairment. On September 30, 1993, Mr. Mann appealed the denial of his claim.

Benefits Review Board Decision

On April 28, 1995, the Benefits Review Board ("BRB" and "Board") affirmed Judge McColgin's finding concerning the presence of coal workers' pneumoconiosis. However, the Board remanded the case to Judge McColgin for reconsideration of the pulmonary functions tests and the total disability determination.

Second Administrative Law Judge Decision

On remand, on November 8, 1995, Judge McColgin determined all the pulmonary function tests were invalid and did not establish total disability. Consequently, Judge McColgin again denied Mr. Mann's claim.

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Modification Request

On March 13, 1996, Mr. Mann submitted additional medical evidence which was treated as a modification request. On July 25, 1996, DOL denied Mr. Mann's modification request and he appealed on August 22, 1996. On September 26, 1996, the case was forwarded to OALJ.

Third Administrative Law Judge Decision

On June 18, 1997, Administrative Law Judge James W. Kerr, Jr., conducted a hearing. On August 22, 1997, Judge Kerr denied Mr. Mann's modification request because he failed to show a change in condition relating to total disability or a mistake in determination of fact. On August 27, 1997, through counsel, Mr. Mann appealed the adverse determination.

Second Benefit Review Board Decision

On September 2, 1998, the Benefits Review Board affirmed Judge Kerr's decision.

Second, and Present, Claim

On May 20, 2002, Mr. Mann filed his second claim for black lung disability benefits (DX 3). DOL denied the claim on June 19, 2003 for failure to establish total disability (DX 22). On June 24, 2003, through counsel, Mr. Mann appealed and the case was forwarded to OALJ on August 19, 2003 (DX 25 and DX 28). Pursuant to a Notice of Hearing, dated January 13, 2005, (ALJ I), I conducted a hearing on April 5, 2005 in Spartanburg, South Carolina, with Mr. Mann, Mr. Stayton, and Mr. Utley present.

Evidentiary Discussion

At the hearing, I deferred a decision on the admission of DX 12. Upon discussion with counsel, I discovered that DX 12 was a positive for pneumoconiosis interpretation by Dr. Miller of the September 9, 2002 chest x-ray obtained during the DOL sponsored pulmonary examination. During that evaluation, Dr. Goldstein had diagnosed the September 9, 2002 chest as positive for black lung, DX 11. Since Claimant's counsel designated two other chest x-ray interpretations[2] as the two permissible case-in-chief radiographic interpretations, and Claimant's counsel acknowledged Dr. Miller's interpretation was not really rebuttal, the admission of DX 12 becomes problematic. Because the Claimant has hit the evidentiary restriction of two case-in-chief chest x-ray evaluations, Dr. Miller's interpretation of the September 9, 2002 film is not admissible under 20 C.F.R. § 725.414 (a) (2) (i). Similarly, since Dr. Miller's ultimate finding does refute or rebut Dr. Goldstein's determination, it is not admissible as rebuttal evidence under 20 C.F.R. § 725.414 (a) (2) (ii). Accordingly, I now determined that DX 12 is not admitted as part of the evidentiary record before me.

Due to the same evidentiary problem, I deferred a decision on EX 4, Dr. Broudy's positive for pneumoconiosis interpretation of the September 9, 2002 chest x-ray, EX 4.

[2]The interpretations of a June 18, 2003 chest x-ray by Dr. Baker and Dr. Miller, CX 1 and CX 3 (ALJ II).

Employer's counsel asserted that Dr. Broudy's associated comments qualified the interpretation as rebuttal. However, since Dr. Goldstein and Dr. Broudy both ultimately found the September 9, 2002 chest x-ray positive for pneumoconiosis, Dr. Broudy's interpretation is not rebuttal under 20 C.F.R. § 725.414 (a) (3) (ii). At the same time, even with the admission of EX 1, as discussed below, the Employer has not exceeded its two case-in-chief chest x-ray interpretations limit. Consequently, I now admit EX 4 under 20 C.F.R. § 725.414 (a) (3) (i) as one case-in-chief x-ray.

Next, I turn to Dr. Broudy's interpretation of the August 5, 2004 chest x-ray, EX 1, which was initially offered as a rebuttal reading to Dr. Galphin's interpretation of the August 5, 2004 radiographic film (positive for pulmonary fibrosis). At the hearing, Employer's counsel agreed Dr. Broudy's reading wasn't really rebuttal and acknowledged a comment by Claimant's counsel that it might be considered a case-in-chief x-ray (TR, page 28). At the hearing, because the August 5, 2004 chest x-ray had not yet been provided to Claimant's counsel for a re-reading,[3] I deferred an admissibility decision on EX 1. As discussed next, Claimant's counsel was able to obtain a post-hearing reading of the August 5, 2004 chest x-ray. As a result, I now admit EX 1 as the second of the Employer's case-in-chief chest x-rays under 20 C.F.R. § 725.414 (a) (3) (i).

On August 23, 2005, I received from Claimant's counsel, Dr. Alexander's interpretation of the August 5, 2004 chest x-ray, which diagnosed simple coal workers' pneumoconiosis and possible Category A large opacity. I have marked Dr. Alexander's reading as CX 9 and now admit his interpretation into evidence under 20 C.F.R. § 725.414 (a) (2) (ii) as a rebuttal chest x-ray to Dr. Broudy's interpretation of the same film which did not show a large pulmonary opacity.

Claimant's counsel also requested the record remain open to in order to obtain the actual CT scan report referenced by Dr. Galphin as part of his pulmonary evaluation conducted on August 5, 2004, CX 2. On August 23, 2005, I received Dr. Aitchison's original reading of the August 5, 2004 CT scan, which I have marked as CX 8 and now admit.

Post hearing, I received from Employer's counsel the qualifications of Dr. Selby, which I have marked as EX 6. Claimant's counsel had no objection to the submission. Accordingly, EX 6 is admitted.

Post hearing, Employer's counsel submitted a re-reading by Dr. Broudy of a January 31, 2005 chest x-ray, which I have marked as EX 7. As Claimant's counsel subsequently noted in objecting to the submission, the patient identified on the chest x-ray is not Mr. Mann. Accordingly, EX 7 is not admitted.

Finally, although I identified the following issue at the hearing, I did not resolve it. As part of his August 5, 2004 pulmonary evaluation and report, Dr. Galphin interpreted the chest x-ray, finding evidence of pulmonary fibrosis. Though his evaluation of the examination chest x-ray was obviously medically sound, Dr. Galphin's interpretation nevertheless exceeds the Claimant's case-in-chief chest x-ray interpretation evidentiary restriction under 20 C.F. R § 725.414 (a) (2) (i). As a result, Dr. Galphin's interpretation of the August 5, 2004 chest x-ray is not admissible.

[3]Dr. Galphin conducted the August 5, 2004 pulmonary examination at the request of the Employer.

The inadmissibility of Dr. Galphin's evaluation of the August 5, 2004 radiographic study raises another evidentiary problem unique to the new regulatory evidence restrictions because under 20 C.F.R. §§ 725.414 (a) (2) (i) and 3 (i) "any chest X-ray interpretation, pulmonary function test results, blood gas studies . . . and physician opinions that appear in a medical report must each be admissible . . ." under the regulations. In *Harris v. Old Ben Coal Co.,* 23 B.L.R. 1-___, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc), the Benefits Review Board indicated that when confronted with a medical opinion that contained evidence not admitted into the formal record, an administrative law judge may: a) exclude the report; b) redact the objectionable content; c) require a revised report; or, d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report. In the present case, I will apply a combination of the second and fourth options. First, I will not consider Dr. Galphin's interpretation of the August 5, 2004 chest x-ray during my adjudication. Second, since the admissible CT scan interpretation reviewed by Dr. Galphin contained essentially the same results as his inadmissible chest x-ray interpretation, I do not believe the presence of the inadmissible interpretation adversely affects the probative value of his opinion.

In summary, due to the interminable evidentiary rulings above, my decision in this case is based on the hearing testimony and the evidence I have now admitted into evidence: DX 1 to DX 11, DX 13 to DX 28, CX 1 to CX 9, EX 1 to EX 6.

ISSUES

1. Whether in filing a subsequent claim in May 20, 2002, Mr. Mann has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement upon which the affirmed denial of his most recent prior claim was based in August 1997.

2 If Mr. Mann establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the March 16, 2005 hearing, the parties stipulated: a) Mr. Mann had at least 39 years of coal mine employment; b) Mrs. Leoma Mann is a dependent for the purposes of augmenting any benefits that may be payable under the Act; and, c) Pittsburg & Midway Coal Mining Company, as successor to Kaiser Coal Corporation, is the responsible operator (TR, pages 8 to 10).

Preliminary Findings

Born on April 1, 1922, Mr. Mann married Mrs. Leoma Mann on March 18, 1946. With the exception of four years service as U.S. Marine in World War II,[4] Mr. Mann worked as a coal

[4]Mr. Mann fought at Guadalcanal, Rendova, Bougainville, and Iwo Jima and suffered shrapnel wounds in combat.

miner from 1940, when he hand loaded coal, through 1984. During about the last 11 years of his coal mining, Mr. Mann worked as a shift foreman, working on a beltline for a "deep" mine in New Mexico.[5] His work required Mr. Mann to lift 50 pound rock dust bags and walk up to five miles a day. Mr. Mann stopped mining coal in 1984 because he couldn't handle the work anymore. Starting in 1983, Mr. Mann smoked cigarettes occasionally for a few years. (DX 1, DX 3, CX 7, and TR, pages 38 to 48)

Issue #1 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. 20 C.F.R. § 725.309 (d) (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

To receive black lung disability benefits under the Act, a claimant must prove four basic conditions, or elements, related to his physical condition. First, the miner must establish the presence of pneumoconiosis.[6] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] Third, the miner has to demonstrate he is totally disabled.[8] And fourth, the miner must prove the total disability is due to pneumoconiosis.[9]

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[5]Since Mr. Mann last mined coal in New Mexico, his case falls within the jurisdiction of the U.S. Court of the Appeals for the Tenth Circuit. *See Shupe v. Director, OWCP,* 12 B.L.R. 1-200, 1-202 (1989) (en banc).

[6]20 C.F.R. § 718.202.

[7]20 C.F.R. § 718.203 (a).

[8]20 C.F.R. § 718.204 (b).

[9]20 C.F.R. § 718.204 (a).

Based on those four principle conditions of entitlement, the adjudication of a subsequent claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to now prove that condition(s) of entitlement. Mr. Mann's prior claim was finally denied in August 1997 for failure to prove that he is totally disabled from a respiratory standpoint. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since the record closed in 1997 to determine whether Mr. Mann can now prove that he is totally disabled.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

Mr. Mann has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. Mann must demonstrate total respiratory or pulmonary disability through the presence of complicated pneumoconiosis, pulmonary function tests, arterial blood-gas tests, or medical opinion.

Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921 (c) (3) (A) and (C), as implemented by 20 C.F.R. § 718.304 (a), Congress determined that if a miner is suffering from a chronic dust disease of the lung "which when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C…there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis…"[10] This type of large opacity is called "complicated

[10]On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes of opacities, identified by letters. The interpretation finding of Category A indicates the presence of a large

pneumoconiosis." 20 C.F.R. §§ 718.304 (b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

All evidence relevant to whether the miner has complicated pneumoconiosis must be weighed. *Gray v. SLC Coal Co*., 176 F.3d 382 (6th Cir. 1999), *Melnick v. Consolidation Coal Co.,* 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985). Therefore, even after the presence of large opacities have been established through one of the three methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine whether the large opacities actually exist and represent complicated pneumoconiosis. For example, the Benefits Review Board affirmed a finding of complicated pneumoconiosis under 20 C.F.R. §718.304 when the administrative law judge considered chest x-rays in conjunction with CT-scan findings to determine there was sufficient evidence to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996). And, in another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a three step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities. Such equivalency determination must be based on medical opinion. *See Lohr v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-1264 (1984) and *Smith v. Island Creek Coal Co.*, 7 B.L.R. 1-734 (1985).

Second, if radiographic, biopsy or other equivalent evidence of large opacities exists, I must evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence does demonstrate the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

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opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities, each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B mean an opacity, or opacities "larger or more numerous than Category A" whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

1. Existence of Large Opacities

In the absence of any biopsy analysis, Mr. Mann must rely on chest x-ray imaging or other equivalent medical tests to establish the presence of large opacities.

Chest X-Rays

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
July 15, 1998	DX 10	Dr. Lee	(Positive for pneumoconiosis). Bilateral interstitial linear and nodular opacities, probable coal workers' pneumoconiosis. (No large opacities reported.)
September 9, 2002	DX 11	Dr. Goldstein, B[11]	Positive for pneumoconiosis, profusion 1/1, [12] type r/u opacities.[13] No large opacities present
(same)	EX 4	Dr. Broudy, B	Positive for pneumoconiosis, profusion category 1/2, type q/r opacities. No large opacity present.
June 18, 2003	CX 1 & CX 4	Dr. Baker, B	Positive for pneumoconiosis, profusion 2/1, type t/q opacities. No large opacities present
(same)	CX 3 & CX 6	Dr. Miller, B, BCR	Positive for pneumoconiosis, profusion 3/2, type q/t opacities. Category A (12 mm) large opacity present in the right lateral mid lung
(same)	EX 3	Dr. Broudy, B	Positive for pneumoconiosis, profusion 1/1, type p/q opacities. No large opacity present
August 5, 2004	EX 1	Dr. Broudy, B	Positive for pneumoconiosis, profusion 1/2, type p/q opacities. No large opacity present
(same)	CX 9	Dr. Alexander, B, BCR	Positive for pneumoconiosis, profusion 1/2, type q/t opacities. 15 mm triangular shaped density, possible Category A complicated pneumoconiosis, present in the medial right upper zone.

[11]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may posses to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs. *See also* 20 C.F.R. § 718.202 (a) (1) (ii).

[12]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

[13]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

Two of the four chest x-rays failed to show the presence of complicated pneumoconiosis. Based on the undisputed opinions, neither the July 15, 1998 nor the September 9, 2002 chest x-rays show the presence of a large opacity.

The physicians disagreed concerning the June 18, 2003 film. Neither Dr. Baker nor Dr. Broudy, two B readers, observed a large opacity. In contrast, Dr. Miller, a dual qualified radiologist, diagnosed a Category A large opacity. In resolving this dispute, I give greater probative weight to Dr. Miller's assessment based on his superior credentials.[14] Consequently, based on Dr. Miller's more probative interpretation, I find the June 18, 2003 is positive for a large, Category A opacity.[15]

The August 5, 2004 chest x-ray generated the same dispute between a B reader and a better qualified radiologist. Though Dr. Broudy did not observe a large opacity, Dr. Alexander, a dual qualified radiologist, reported a 15 mm triangular density, Category A, in the right upper lung zone, which he believed possibly represented complicated pneumoconiosis. Again, relying on Dr. Alexander's more probative interpretation, I find the August 4, 2004 chest x-ray is positive for the presence of a large Category A pulmonary opacity consistent with complicated pneumoconiosis.

Though only two of the four chest x-ray reveal the presence of a large pulmonary opacity, those two films are significantly the two most recent radiographic studies. Under the regulations, 20 C.F.R. § 718.201 (c), pneumoconiosis "is recognized as a latent and progressive disease which may become detectable only after the cessation of coal mine dust exposure." Consequently, based on the more probative interpretations of the two most recent radiographic studies from 2003 and 2004, I find that Mr. Mann has established the presence of a Category A large pulmonary opacity under 20 C.F.R. § 718.304 (a).

2. Other Evidence of a Large Pulmonary Opacity

As a second step the analysis of complicated pneumoconiosis, I must consider other whether other evidence in the record either confirms or contradicts the radiographic presence of a large pulmonary opacity. Since no biopsy evidence exists in this case, the additional evidence consists of a CT scan analysis and medical opinion.

[14]*See Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003) and *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (greater probative weight may be given to the interpretations of a dual qualified radiologist in comparison to a physician who is only a B reader.)

[15]Although Dr. Miller's interpretation of the September 9, 2002, DX 12, was not admitted due to the evidentiary restrictions, I am aware that in the earlier chest x-ray, after diagnosing the presence of simple coal workers' pneumoconiosis, profusion 3/2, type q/r opacities, Dr. Miller did not report the presence of a large, Category A opacity. Dr. Miller did not specifically explain the reason for his two differing interpretations concerning the presence of a large opacity. However, Dr. Miller graded the film quality of the September 9, 2002 chest x-ray as 2; whereas, he found the June 18, 2003 film to be of a better quality, grade 1.

CT Scan[16]
(CX 8)

Dr. Paul Aitchison, a board certified radiologist, interpreted an August 5, 2004 CT scan. The physician observed silicosis with pulmonary fibrosis, stellate areas of nodularity within both lungs, "focal areas of progressive massive fibrosis in the left upper lobe," multiple calcified pulmonary nodules, and "an oval 7 mm subpleural nodule on the right."

In his evaluation, Dr. Aitchison specifically identified the presence of a 7 mm pulmonary nodule in the same relative area as the large radiographic opacity observed by Dr. Miller and Dr. Alexander. To determine the extent to which Dr. Aitchison's CT scan finding may confirm or contradict the reported size of the chest x-ray opacity requires an equivalency determination by a physician. However, the record before me does not contain such a medical assessment. As a result, while Dr. Aitchison's CT scan analysis confirms the presence of a pulmonary nodule in Mr. Mann's right lung, his assessment does not confirm or contradict the assessments by Dr. Miller and Dr. Alexander that the nodule appeared as a 12mm to 15mm opacity on chest x-rays.[17]

Medical Opinion

As noted above, when Dr. Baker examined Mr. Mann on June 18, 2003, he did not observe any large opacity in the chest x-ray and did not diagnose complicated pneumoconiosis. However, I have determined that Dr. Miller has provided a more probative opinion on whether a large radiographic opacity is present in the June 18, 2003 chest x-ray.

When Dr. Galphin examined Mr. Mann on August 4, 2004, he interpreted the examination chest x-ray and did not report the presence of a large pulmonary opacity. Correspondingly, he did not diagnose complicated pneumoconiosis. However, his radiographic interpretation has little probative value for two reasons. First, and most significant, since his interpretation exceeded the evidentiary restrictions, I have already concluded Dr. Galphin's interpretation of the August 4, 2004 chest x-ray is not admissible. Second, even if Dr. Galphin's reading had been admissible, it would have less probative value than Dr. Alexander's evaluation since Dr. Galphin is not a dual qualified radiologist.

[16]Since CT scans are considered "other medical evidence" under 20 C.F.R. §718.107, the Benefits Review Board has determined no regulatory evidentiary limits exist on the number of case-in-chief CT scan interpretations. *Dempsey v. Sewell Coal Co.,* 23 B.L.R. 1-47 (2004) (en banc). At the same time, 20 C.F.R. § 725.414 limits the opposing party to one interpretation for each CT submission.

[17]According to the U.S. Court of Appeals for the Fourth Circuit in *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256 (4th Cir. 2000), based on the congressionally defined criteria for complicated pneumoconiosis, radiographic evidence of one or more large opacities categorized as size A, B, or C, represents the most objective measure of the condition. In contrast, in *Gray v. SLC Coal Co.*, 176 F.3d 382, 390, 388-391 (6th Cir. 1999), the U.S. Court of Appeals for the Sixth Circuit stated chest x-rays are the least accurate method of establishing complicated pneumoconiosis.

When Dr. Selby considered Mr. Mann's pulmonary condition in March 2005, he only reviewed the chest x-ray interpretations by Dr. Barker and Dr. Galphin. As a result, he was not aware of the large opacity findings by Dr. Miller and Dr. Alexander and thus did not address whether such an opacity was present. Consequently, Dr. Selby's record review does not contradict the large pulmonary opacity findings by Dr. Miller and Dr. Alexander.

Summary

Since neither the CT scan interpretation nor the opinions of Dr. Baker, Dr. Galphin, and Dr. Selby provide sufficient contrary evidence, I find the interpretations by Dr. Miller and Dr. Alexander of the June 2003 and August 2004 chest x-rays establish the presence of a large, Category A radiographic opacity.

3. Other Medical Evidence

Since Mr. Mann has proven the existence of a large category opacity, I must move to the third adjudicative step and consider other relevant medical evidence prior to making a determination of whether Mr. Mann has invoked the 20 C.F.R. § 718.304 presumption. This analysis is focused on whether the other evidence in the record indicates some other pathology, rather than a disease related to coal dust exposure, explains the presence of the opacities.

Pulmonary Test Results

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[18] post[19]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[20] pre Post**	**Comments**
DX 10	July 15, 1998 Dr. Mayson	76 68.5"[21]	1.11	1.35	---	82%	Yes[22]	(No tracings)
DX 11	October 3, 2002 Dr. Mayson	80 68"	1.75	2.36	60	76%	No[23]	Good cooperation & under - standing

[18]Test result before administration of a bronchodilator.

[19]Test result following administration of a bronchodilator.

[20]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[21]Dr. Mayson did not annotated Mr. Mann's height. Consequently, I will apply Mr. Mann's stated height (TR, page 48).

[22]The qualifying FEV1 number is 1.76 for age 76 (71 maximum age on table) and 68.5″; the corresponding qualifying FVC and MVV values are 2.28 and 70, respectively.

[23]The qualifying FEV1 number is 1.69 for age 80 (71 maximum age on table) and 68″; the corresponding qualifying FVC and MVV values are 2.20 and 68, respectively.

CX 1 & CX 4	June 18, 2003 Dr. Baker	81 65.6″	1.21	2.19	---	55%	Yes[24]	Invalid – insufficient patient effort.
CX 2 & CX 5	August 5, 2004 Dr. Galphin	82 68.5"[25]	1.03	1.6	----	64%	Yes[26]	(No tracings)

Arterial Blood Gas Studies[27]

Exhibit	Date / Doctor	pCO^2 (rest) pCO^2 (exercise)	pO^2 (rest) pO^2 (exercise)	Qualified[28]	Comments
DX 10	July 15, 1998 Dr. Mayson	40	65	No[29]	
DX 11	October 3, 2002 Dr. Mayson	40.6 37.1	69 103	No No[30]	
CX 1 & CX 4	June 18, 2003 Dr. Baker	39	74	No[31]	

Dr. Rayman Lee[32]
(DX 10)

On July 15, 1998, upon referral from a treating physician, Dr. Lee, board certified in pulmonary disease, internal medicine, and critical care medicine, evaluated Mr. Mann for black lung disease. Mr. Mann had mined coal for between 40 to 45 years. He complained about shortness of breath upon exertion. Upon physical examination, Dr. Lee heard very mild bilateral crackles. The chest x-ray revealed bilateral interstitial linear and nodular opacities, probably coal workers' pneumoconiosis. The pulmonary function tests results were significantly below the expected values. Based on Mr. Mann's employment history, chest x-ray and pulmonary

[24]The qualifying FEV1 number is 1.51 for age 81 (71 maximum age on table) and 65.5″; the corresponding qualifying FVC and MVV values are 1.96 and 60, respectively.

[25]Since Dr. Galphin did not indicated Mr. Mann's measure height, I will utilized Mr. Mann's stated height.

[26]The qualifying FEV1 number is 1.76 for age 82 (71 maximum age on table) and 68.5″; the corresponding qualifying FVC and MVV values are 2.28 and 70, respectively.

[27]Although Dr. Galphin conducted an arterial blood gas study and found 94% oxygen saturation, the physician did not provide the actual test results. As a result, I have not listed the August 5, 2004 arterial blood gas study by Dr. Galphin.

[28]Under 20 C.F.R. § 718.204 (b) (2) (ii) (2001), to qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[29]For a pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[30]For a pCO^2 of 37, the qualifying pO^2 is 63, or less.

[31]For a pCO^2 of 39, the qualifying pO^2 is 61, or less.

[32]Since Dr. Lee conducted his evaluation as part of treatment for Mr. Mann's pulmonary difficulties, his examination is admissible under 20 C.F.R. § 725.414 (a) (4).

function test, Dr. Lee diagnosed coal workers' pneumoconiosis. In response, the physician prescribed supportive care and treated Mr. Mann with a pulmonary puffer.

Dr. Mark J. Mayson
(DX 11)

On October 3, 2002, Dr. Mayson, board certified in pulmonary disease,[33] evaluated Mr. Mann's pulmonary condition. Mr. Mann had been a coal miner from the 1940s through May 1984. He last worked in the coal mines as a foreman. Mr. Mann never smoked cigarettes. His medical history included congestive heart failure and arthritis. He complained about disabling shortness of breath. The chest physical examination was normal. The chest x-ray revealed diffuse interstitial fibrosis. The pulmonary function test results were 62% to 74% of the expected values. Based on the examination, Dr. Mayson diagnosed probable pneumoconiosis, related to coal dust or silica exposure. Mr. Mann was severely impaired and his shortness of breath was attributable the fibrosis, heart disease, weakness and arthritis.

Dr. Glenn R. Baker
(CX 1 & CX 4)

On June 18, 2003, Dr. Baker, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation. Mr. Mann had worked for more than 11 years in coal mining and never smoked cigarettes. He complained about chronic shortness of breath. Upon physical examination, Dr. Baker heard diminished breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests showed a moderate obstructive defect. The arterial blood gas study indicated mild resting hypoxemia. Based on the chest x-ray and Mr. Mann's history of coal mine employment, Dr Baker diagnosed coal workers' pneumoconiosis. Mr. Mann also had chronic bronchitis and COPD (chronic obstructive pulmonary disease), attributable to his coal dust exposure. Based on the low FEV_1 on the pulmonary function test, Dr. Baked opined Mr. Mann was totally disabled. However, Dr. Baker indicated the pulmonary function tests were invalid due to Mr. Mann's insufficient and questionable effort. Mr. Mann's coal dust-related pulmonary defects contributed fully to his respiratory impairment.

Dr. Robert L. Galphin. Jr.
(CX 2 & CX 5)

On August 5, 2004, Dr. Galphin conducted a pulmonary examination. Mr. Mann had mined coal for 44 years. Although Mr. Mann stated he was non-smoker, records indicated a minimal cigarette smoking history. Mr. Mann struggled with long-term and worsening shortness of breath upon exertion. His medical history included severe arthritis and congestive heart failure and a stent operation. Though Mr. Mann had difficulty following directions and staying awake, the pulmonary function test indicted the presence of a significant restrictive disease associated with pneumoconiosis and pulmonary fibrosis. The pulmonary function test, coupled with Mr. Mann's history, led Dr. Galphin to conclude Mr. Mann had a severe degree of pulmonary impairment. The resting arterial blood gas study was normal. A CT scan revealed

[33]As I advised the parties at the hearing (TR, page 6), I take judicial notice of Dr. Mayson's board certification and have attached the certification documentation.

the presence of pulmonary fibrosis and progressive massive fibrosis. Based on the examination, Dr. Galphin opined Mr. Mann was severely disabled by pulmonary fibrosis consistent with coal workers' pneumoconiosis.

Dr. Jeff W. Selby
(EX 2 & EX 6)

On March 3, 2005, Dr. Selby, board certified in pulmonary and internal medicine and critical care, reviewed the pulmonary evaluation results and forms from Dr. Mason, Dr. Baker, and Dr. Galphin. First, highlighting the dramatic rise in PO_2, upon exercise during Dr. Mayson's testing, Dr. Selby concluded Mr. Mann had "phenomenal preservation of cardiopulmonary function under stress and exercise," such that despite subjective complaints of shortness of breath "in this situation, there can be no disability" because "the arterial blood gas studies. . . are the final most reliable objective testing. . ." Consequently, even if the chest x-rays establish the presence of coal workers' pneumoconiosis, that condition "is not disabling." Second, concerning Dr. Baker's evaluation, Dr. Selby believed the pulmonary function tests were not valid due to several deficiencies. The physician also observed that the resting arterial blood gas test result was above the disability standard. Third, in Dr. Galphin's examination, no arterial blood gas testing was conducted and no tracings for the pulmonary function tests were provided which precludes assessing their validity. Though the CT scan report indicated abnormalities consistent with silicosis and pulmonary fibrosis, Dr Selby questioned the definitive nature of the report because "there may be upwards of one hundred different interstitial lung diseases that could potentially mimic the pulmonary fibrosis of silicosis and coal workers' pneumoconiosis." Consideration of an idiopathic interstitial lung disease was appropriate in Mr. Mann's case considering that he did not have severe lung disease when he left coal mining 18 years earlier and his exceptional exercise arterial blood gas test results. In summary, based on the high exercise PO_2 value, and noting the absence of any valid pulmonary function test, Dr. Selby opined Mr. Mann does not have a totally disabling respiratory or pulmonary impairment. The exercise blood gas study shows Mr. Mann had the respiratory capacity to return to coal mining.

Dr. Michael S. Alexander
(CX 9)

In his interpretation of the August 5, 2004, Dr. Alexander, a board certified radiologist and B reader, placed a "?" next to his indication on the ILO form that a large, Category A pulmonary opacity was present. In the comments section, Dr. Alexander stated, "possible 15 mm large opacity of complicated CWP (coal workers' pneumoconiosis) in medical right upper zone." In his cover letter, Dr. Alexander further indicated that the 15 mm triangular shaped density may indicate complicated coal workers' pneumoconiosis. The physician added that the quality of the film, grade 3, imposed "diagnostic limitations."

Discussion

In assessing this additional medical evidence, my inquiry is focused on whether the Category A large opacity is related to a chronic dust disease of the lung. Considering first the pulmonary test results, the absence of the requisite tracings render two of the studies non-

conforming and another test was invalid. As a result, only one test from October 3, 2002 appears to be conforming and valid. During that test, Mr. Mann did not reach the total disability threshold. Similarly, all the arterial blood gas studies show Mr. Mann has retained sufficient blood oxygenation capacity. However, the absence of a demonstrated totally disabling respiratory impairment does not definitively establish that Mr. Mann does not nevertheless suffer with a coal dust related lung disease. In general, the pulmonary capacity tests measure the severity of a pulmonary impairment and do not isolate its etiology. Additionally, if a large pulmonary opacity of complicated pneumoconiosis is present, the absence of pulmonary testing reaching total disability thresholds does not preclude invocation of the congressionally-mandated irrebuttable total disability presumption under 20 C.F.R. § 718.304.

As a preliminary matter, I do not consider Dr. Alexander's diagnosis of "probable" complicated pneumoconiosis in his chest x-ray interpretation to be sufficient evidence that the large opacity is not related to a chronic dust lung disease. Instead, Dr. Alexander was indicating that based solely on the chest x-ray, he could only at best diagnose "probable" complicated pneumoconiosis.

Turning to the remaining medical opinion, based on Mr. Mann's work and social histories, his clinical presentation, a full pulmonary examination and consideration of the radiographic evidence, Dr. Lee, Dr. Mayson, Dr. Baker, and Dr. Galphin concluded Mr. Mann had coal workers' pneumoconiosis, a chronic dust lung disease. Although I was unable ascertain whether Dr. Galphin is board certified, the other three physicians who most recently diagnosed Mr. Mann with black lung disease are board certified in pulmonary disease.

Upon reviewing the results of the various pulmonary examinations, including the radiographic and CT scan results, Dr. Selby, also board certified in pulmonary medicine, first noted that even if Mr. Mann had coal workers' pneumoconiosis, it was not disabling in light of Mr. Mann's exceptional arterial blood gas test result. Then, Dr. Selby questioned the diagnosis of coal workers' pneumoconiosis since nearly one hundred interstitial lung diseases could produce the pulmonary fibrosis observed in the radiographic studies. Considering Mr. Mann's arterial blood gas studies and his long absence from coal mine employment, Dr. Selby believed consideration of idiopathic pneumoconiosis was warranted.

In evaluating this conflict in medical opinion, I believed all the physicians had a firm documentary basis for their opinions. Additionally, in light of the documentation before them, the physicians presented generally reasoned assessments. In that regard, Dr. Selby's reliance on Mr. Mann's long absence from coal mining as a determinative factor may run counter to the previously noted regulatory definition of coal workers' pneumoconiosis as a progressive and latent disease. I also note Dr. Selby's failure to address how his idiopathic pneumoconiosis. diagnosis was consistent with the fact that the sole significant pulmonary risk factor for Mr. Mann was his 40 years of coal dust inhalation. However, my resolution of this issue doesn't rest on any reasoning deficiency in Dr. Selby's analysis. Instead, I find the significant preponderance of the medical evidence and opinion clearly demonstrates that Mr. Mann has coal workers' pneumoconiosis. Significantly, <u>every</u> radiologist and B reader who interpreted the radiographic films since 1997 found interstitial fibrosis that was consistent with coal workers' pneumoconiosis. Notably, not one of these experts suggested any other possible type of fibrosis.

Their consistent analysis was further validated by the board certified radiologist who evaluated the CT scan and found evidence of silicosis and progressive massive fibrosis. According to 20 C.F.R. § 718.201 (a) (1), "silicosis" falls within the definition of clinical pneumoconiosis. Under this regulatory provision, silicosis represents the permanent deposition of substantial amounts of particulate matter in the lungs and a corresponding fibrotic reaction. Most significant, upon consideration of the objective pulmonary tests and radiographic evidence, three out of the four board certified pulmonary medical experts diagnosed Mr. Mann with coal workers' pneumoconiosis. In other words, the consensus of Dr. Lee, Dr. Mayson, and Dr. Baker that Mr. Mann has coal workers' pneumoconiosis outweighs Dr. Selby's diagnosis of idiopathic pneumoconiosis.

Since the preponderance of the radiographic evidence and medical opinion establishes that Mr. Mann has coal workers' pneumoconiosis, I conclude that Mr. Mann has a chronic dust lung disease. Consequently, the preponderance of the radiographic evidence and medical opinion supports, rather than contradicts, a finding that the large Category A pulmonary opacity is related to his chronic dust lung disease. Accordingly, I conclude Mr. Mann is able to invoke the presumption under 20 C.F.R. § 718.304 (a) through the presence of a Category A opacity in his two most recent chest x-rays establishing the presence of complicated pneumoconiosis. Having invoked the presumption, which is irrebuttable, Mr. Mann is able to rely on that invocation to establish that he now totally disabled due to a respiratory impairment. By establishing the presence of a totally disabling pulmonary impairment, Mr. Mann has also now proven an applicable condition of entitlement previously adjudicated against him as required by 20 C.F.R. § 725.309 (d). As a result, I will review the entire record to determine whether he is entitled to black lung disability benefits.

Issue # 2 – Entitlement to Benefits

Again, to establish entitlement to black lung disability benefits under Act, Mr. Mann must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[34] The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[35] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[36] As courts have

[34]20 C.F.R. § 718.201 (a).

[35]20 C.F.R. §§ 718.201 (a)(1) and (2).

[36] 20 C.F.R. § 718 (b).

noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),[37] and medical opinion (§ 718.202 (a)(4)).

Upon review of the entire record, I believe the preponderance of radiographic medical evidence since the early 1990s established that Mr. Mann had pneumoconiosis. Additionally, by invoking the irrebuttable presumption under 20 C.F.R. § 718.304 (a), Mr. Mann is able to establish the presence of pneumoconiosis through the operation of 20 C.F.R. § 718.202 (a) (3).

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of pneumoconiosis, Mr. Mann must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. § 718.203 (b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. As the parties stipulated, Mr. Mann had at least 39 years of coal mine employment. As a result, he is entitled to the regulatory presumption. Upon consideration of the entire record, I find insufficient evidence to rebut that causation presumption. Accordingly, based on the 20 C.F.R. § 718.203 (b) presumption, I find Mr. Mann's pneumoconiosis is due to his coal mine employment.

Total Disability and Total Disability Due to Coal Workers' Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to coal workers' pneumoconiosis. Through the recent invocation of the irrebuttable presumption under 20 C.F.R. § 781.304 (a) and under 20 C.F.R. § 718.203 (b) due to 39 years of coal mine employment, Mr. Mann has established total disability due to coal workers' pneumoconiosis.

CONCLUSION

Based on the presence of a large Category A opacity in the two most recent chest x-rays, and because the preponderance of the radiographic evidence and medical opinion establish the presence of a chronic dust lung disease, Mr. Mann has invoked the irrebuttable presumption of total disability due to pneumoconiosis under 20 C.F.R. § 718.304 (a). That invocation also establishes a change in condition of entitlement previously adjudicated against him as required by 20 C.F.R. § 725.309 (d). Upon consideration of the entire record, and through the un-rebutted

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[37]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

presumption under 20 C.F.R. § 718.203 (b) and the invoked irrebuttable presumption under 20 C.F.R. § 718.304 (a), I find that Mr. Mann is totally disabled due to coal workers' pneumoconiosis. Accordingly, Mr. Mann's claim for black lung disability benefits must be approved.

Date of Entitlement

Under 20 C.F.R. § 725.503 (b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total pulmonary disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, "[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented."

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. *See Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is "first able to muster evidence of total disability is not necessarily the date of onset").

Finally, according to 20 C.F.R. § 309 (d) (5), when an award is made in a subsequent claim, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

Mr. Mann's prior claim was finally denied in September 1998 and he filed his present subsequent claim in May 2002. When Dr. Mayson conducted his pulmonary examination in October 2002, the associated chest x-ray, dated September 9, 2002, did not indicate the presence of a large pulmonary opacity. The complicated pneumoconiosis lesion did not become apparent and establish total disability until the June 18, 2003 chest x-ray. As a result, the record establishes that at least between May 2002 and September 9, 2002, Mr. Mann was not totally disabled. Since he was not totally disabled during this period, , Mr. Mann is not entitled to black lung disability benefits from May 2002 through September 2002. Consequently, I find the appropriate date of entitlement is October 1, 2002.

Augmentation

Since the parties have stipulated that Mrs. Leoma Mann is a dependent for purposes of augmenting any benefits that may be payable under the Act, Mr. Mann's entitlement will be augmented for his spouse.

Attorney Fees

Counsel for the Claimant has thirty calendar days from receipt of this decision and order to submit an application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen calendar days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with this claim.

ORDER

The claim of MR. CARL E. MANN for benefits under the Act is **GRANTED**. PITTSBURG & MIDWAY COAL MINING CO. is ordered to pay MR. CARL E. MANN all benefits to which he is entitled under the Act and Regulations. Benefits shall commence October 1, 2002, augmented for his spouse, MRS. LEOMA MANN.

SO ORDERED:

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RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: June 19, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

Mark J. Mayson, MD

Certified by the American Board of Internal Medicine in:

Pulmonary Disease

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